REFORMED COMMITMENT PROCEDURES: AN EMPIRICAL STUDY IN THE COURTROOM

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Court proceedings and records were analyzed to evaluate statutory reform of mental commitment procedure in one state with a typical statute. A marked improvement over practice described in previous research was found: court proceedings were not rapid and perfunctory. However, the court still often deferred to psychiatric opinion even when a preponderance of evidence showed it to be unsubstantiated.

Under its police power and its *parens patriae* function, the state has committed individuals to mental hospitals in order to protect the safety and welfare of the public and of persons incapable of caring for themselves.[1] Unfortunately, as many studies have shown, commitment procedures have failed to ascertain whether the welfare and safety of the public or the individual were sufficiently endangered to justify the state in removing an individual from society and incarcerating him in a mental hospital. Cursory psychiatric examination (Kutner, 1962; Scheff, 1964a, 1964b) and perfunctory court hearings (Dershowitz, 1968; Cohen, 1966; Maisel, 1970; Miller and Schwartz, 1966; Scheff, 1964b; Shah, 1974; Wenger and Fletcher, 1969) have been the procedural norm, resulting in commitment of most persons, especially those of the lower class, once proceedings were begun against them. The monopoly of knowledge claimed by physicians and the enormous powers of the state have overwhelmed individuals who were already weak adversaries and forced them into confinement in mental hospitals, frequently for indeterminate periods.

Recently, the federal judiciary has strengthened the individual vis-à-vis the state and the physician by extending civil rights to mental patients and those the state seeks to confine.[2] Ancient common law principles of justice, such as the rights to notice,

Preparation of this paper was supported by NIMH Grant MH13112 to the Departments of Sociology and Psychiatry, Duke University. Particular thanks are expressed to Management Information System—Statistics, North Carolina Division of Mental Health Services, which provided state hospital data, and to court officials who gave their time and energy to facilitate court data collection.

1. Throughout this paper commitment and involuntary admission will refer only to the civil procedure, and will exclude criminal commitment and criminal involuntary admission.
2. For instance, *Heryford* v. *Parker*, 396 F.2d. 393 (10th Cir. 1968) (right to counsel); *In re Bailey*, 482 F.2d. 648 (D.C. Cir. 1973) (high standard of proof); *O'Connor* v. *Donaldson*, 422 U.S. 563 (1975) (right to regular review of continued commitment); *Wyatt* v. *Stickney*, 344 F. Supp. 373, 387 (M.D. Ala. 1972) *aff'd sub nom. Wyatt* v. *Aderholt*, 503 F.2d 1305 (5th Cir. 1974) (right to treatment). See generally *Harvard Law Review* (1974).

hearing, counsel, to confront witnesses, to speedy procedure and regular review, have been asserted by various courts as essential to due process in commitment procedures. Most states have responded by rewriting their statutes governing admission to, care in, and discharge from mental hospitals. Although professional recommendations and judicial decisions were embodied in new legislation to assure due process and civil liberties, little empirical evidence has been collected to demonstrate that the laws achieve these goals. The question is not only whether practice follows the statute, but also whether due process results from such adherence. By examining statutory reform in one representative state, North Carolina, this paper addresses the problem of whether these new laws protect allegedly mentally ill individuals in commitment proceedings.

THE NORTH CAROLINA CIVIL COMMITMENT STATUTE

In 1973, the North Carolina General Assembly rewrote its mental commitment statute with an explicitly stated intent: to reduce involuntary commitment, to encourage voluntary admission in place of involuntary commitment, to grant due process to respondents subject to involuntary commitment procedures, to ensure the right to treatment and basic human rights to both voluntary and involuntary mental patients, and to assure discharge from mental hospitalization as soon as a less restrictive mode of treatment is possible (N.C.G.S. §§ 122-55.1, 122-58.1).[3]

Prior to statutory reform, a person could be committed upon certification by two physicians (N.C.G.S. § 122-58(a)), by a court clerk at a hearing (N.C.G.S. § 122-63), or by either a court clerk or a single physician in an emergency (N.C.G.S. § 122-59). Counsel was not provided; the burden of proof was on the respondent; and no court review was provided unless a patient obtained a writ of habeas corpus.

The reformed statute limits the power of the state, allowing it to commit only those individuals who are: (1) mentally ill or inebriate, and (2) imminently dangerous to self or others (N.C.G.S. § 122-58.1). The commitment procedure is initiated with the filing of an affidavit by a petitioner, who may be any citizen, including a law enforcement officer, with knowledge of such an individual (N.C.G.S. § 122-58.3 (a)). Four separate determinations of that condition must be made, by (1) the magistrate or clerk who receives the petition (N.C.G.S. § 122-58.3 (b)), (2) a local qualified

3. The statute was later revised to clarify some areas of confusion and to rectify technical problems in its operation, without changing the original intent of the law (1974: N.C.G.S. §§ 122-58.1 through 122-58.18; 1975: N.C.G.S. §§ 122-58.7(b), 122-55.13-14; 1976: N.C.G.S. § 122-58.7A).

physician who examines the respondent in his county of residence (N.C.G.S. § 122-58.4 (a)), (3) a qualified physician at a treatment facility (N.C.G.S. § 122-58.4 (c)), and (4) a district court judge at a hearing (N.C.G.S. § 122-58.7). Any one of the four may terminate the commitment procedure by finding an insufficient evidence of mental illness or inebriety, or of imminent danger to self or others. In the case of violent behavior, the magistrate may follow an emergency procedure and send the respondent directly to a mental hospital, thus bypassing the evaluation by a local qualified physician (N.C.G.S. § 122-58.18). Time limitations are placed on each stage of fact finding. The examination by a local qualified physician must occur within 24 hours of respondent's presentation to the physician by a law enforcement officer (N.C.G.S. § 122-58.4 (c)); the respondent must be examined by the treatment facility within 24 hours after arrival (N.C.G.S. § 122-58.6 (a)); and the district court hearing must take place within 10 days after the respondent has been taken into custody (N.C.G.S. § 122-58.7(a)). The respondent is given notice of the hearing (N.C.G.S. § 122-58.5) and assigned a lawyer by the court if unable or unwilling to hire private counsel (N.C.G.S. § 122-58.7 (c)). No counsel is provided for the petitioner or the state.[4]

The respondent has the right to be present at the hearing, but may waive this right through counsel with the court's consent (N.C.G.S. § 122-58.7 (d)). Physicians are not required to be present at the hearings since certified copies of their findings are admissible (N.C.G.S. § 122-58.7 (e)). However, the respondent may not be denied the right to confront and cross-examine all witnesses if he so elects (N.C.G.S. § 122-58.7 (e)), so the presence of the examining psychiatrists could be required. The standard of proof is clear, cogent, and convincing evidence—the highest civil standard (N.C.G.S. § 122-58.7 (i)). The respondent has the right to appeal from the judgment of the district court to the Court of Appeals (N.C.G.S. § 122-58.9).

4. An attorney is appointed to represent a respondent unwilling to hire private counsel, although the lawyer does not thereby become a guardian ad litem, nor is the respondent therefore viewed as incompetent.

Although the statute provides that "the district attorney may represent the petitioner in cases of significant public interest" (N.C.G.S. § 122-58.7(b)), this never occurred in practice. The petitioner was represented in only one of the 132 cases observed. In that instance the petitioner (wife of the respondent) retained a lawyer to represent him, but the judge refused to allow the lawyer to appear, and postponed the hearing. The respondent then retained his own counsel, and the wife's attorney represented her as the petitioner. Judges in our study complained that the lack of an advocate for the petitioner or state forced them to look for holes in the respondent's case, and to seek evidence for commitment. One judge disparagingly compared civil commitment to "Star Chamber" proceedings; of course, one situation is in fact the reverse of the other.

Initial civil commitment cannot exceed 90 days (N.C.G.S. § 122-58.8 (b)). At the end of that time, if the patient is not released, a district court hearing is to be held with the same due process provisions as in the initial hearing (N.C.G.S. § 122-58.11 (c)). If the respondent is not released, he is committed for a period not to exceed an additional 180 days (N.C.G.S. § 122-58.11 (d)). Successive recommitments must follow the same procedure, but can be for as long as a year at a time (N.C.G.S. § 122-58.11 (e)).

Neither dangerousness nor imminence is defined in the North Carolina statute beyond the statement that dangerousness "includes, but is not limited to, those mentally ill and inebriate persons who are unable to provide for their basic needs for food, clothing, and shelter" (N.C.G.S. § 122-58.2 (1)). Likewise, mental illness and inebriety are not clearly defined. Thus, although the statute sets the required level of proof at clear, cogent, and convincing evidence, district court judges have great latitude in commitment decisions.

LACUNAE

Despite the procedural requirements of the new legislation, protection of the individual may not have been assured. The statute fails to deal with two factors that contribute to a tendency toward commitment once proceedings have begun: the propensity of psychiatrists to overpredict dangerousness, and the inclination of judges and lawyers to defer to medical opinion. We may assume that none of these actors intends harm to individuals, but certain social forces have been shown to lead to that unfortunate result.

Physicians are socialized to be cautious. They operate on the theory that it is best to treat when in doubt (Shah, 1975); in other words, treatment will not hurt. There is a greater willingness to choose a false positive—to treat a nonsick individual—than a false negative—to allow a sick person go untreated. Furthermore, psychiatrists feel a burden of responsibility for their patients' behavior. They would rather detain a nondangerous person than release a patient who *might* commit a violent act. Whereas little public notice is taken of the numerous former mental patients who are totally harmless, headline stories abound regarding the small number of those released who commit bizarre and dangerous acts. At the same time, little public or psychiatric attention is given to the harm to the patient from confinement in a mental hospital (*Harvard Law Review,* 1974; Rosenhan, 1973). Psychiatrists tend to ignore research which has shown that the great majority of persons committed to mental hospitals because of alleged dangerousness do not perform acts dangerous to self or others upon

release (Livermore *et al.,* 1968; Rosen, 1954; Shah, 1975; Steadman, 1972; Steadman and Cocozza, 1974).

Judges and lawyers tend to be unaware of the weak basis of psychiatric prediction of dangerousness, and hence frequently defer to such "expert" opinion. Lacking knowledge of mental illness and psychiatry, they tend to go along with expert opinion which, in effect, allows psychiatrists to become the effective decision makers, often in absentia (Andalman and Chambers, 1974; Bazelon, 1974; Cohen, 1966; Shah, 1975; Steadman, 1972). An Arizona study showed that court decisions followed psychiatric recommendation in more than 96 percent of all cases (Wexler, Scoville *et al.*, 1971), and other studies have found 100 percent agreement between courts and medical reports (Rock *et al.*, 1968; Wenger and Fletcher, 1969). Not only does the judge often relinquish his function to the psychiatrist, but lawyers do the same. Reports from several states have described counsel as doing "virtually nothing except stand passively at a hearing and add a falsely reassuring patina of respectability to the proceedings" (Andalman and Chambers, 1974). In Wexler's Arizona study, counsel for both sides often acted to present the case against the individual. Where neither counsel nor judge questions conclusory psychiatric labels, commitment hearings are superficial and brief. Scheff (1964a) reported that hearings in an urban court lasted an average of only 1.6 minutes; Wexler, Scoville *et al.* (1971) reported an average of 4.7 minutes in Arizona; and Cohen (1966) an average of 1.9 minutes in Texas. Obviously, little consideration can be given to evidence and to proper disposition of cases heard so quickly.[5] It is possible that deference to psychiatric opinion does not obtain in North Carolina at this time. The recent attention paid to commitment procedures by courts, interest groups, and academic journals, as well as by the legislation itself, may compensate for the statute's lacunae, and may produce judicial—rather than psychi-

5. One study would seem to contradict this view of counsel. Wenger and Fletcher (1969) found that individuals represented by counsel were committed with significantly less frequency and received significantly longer hearings even when mental condition, as evaluated by an observer, was held constant. Since counsel in that study was not provided by the state, legal representation must have been privately retained; and those with counsel must have possessed greater financial resources than those without such representation. Although the authors do not so state, we suspect that private counsel was retained for the sole purpose of fighting commitment, whereas in the case of state appointed counsel, the adversarial role may not be so clearly dictated (Litwack, 1974; Goode, 1975). The role of counsel may be perceived as merely ensuring that procedural formalities are observed and that the doctor's conclusion about "what's best" for the individual is followed. Since new legislation requiring legal representation for allegedly mentally ill persons will mean state appointed counsel for the vast majority involved in civil commitment procedures, we do not think that the findings of Wenger and Fletcher are generalizable to all involuntary commitments.

atric—decisions, as required by the statute and court rulings (N.C.G.S. § 122-58.7 (i); Wexler, Scoville *et al.*, 1971).

This paper will focus on court proceedings rather than examine the entire commitment process from petition through release. Prehearing actions by the petitioner, magistrate, local physician, and hospital physician, which we will ignore, are important in labeling and channeling individuals into the system. But it is to the court that the ultimate commitment decision has been given; and hence, the courtroom is the crucible in which the new legislation is tested.[6] If the new laws are to be effective in ensuring due process and in reducing unnecessary commitments, then the judge must act independently of psychiatric recommendation. This is not to say that he must always disagree with psychiatric opinion, but to insist that the judge must not perform an empty ritual, rubber-stamping medical decisions.

THE SAMPLE

Court records and procedures of one county were studied from September to December 1975. One hundred thirty-two commitment hearings before three rotating judges were observed. Each case file contained petition, custody order, medical reports (including findings, diagnosis, and recommendation), notice of hearing, summons, and court decision. Sampling was based on convenience, but 81.0 percent of all hearings held during the period of the study were observed.

The sampled county is predominantly urban, the site of a major university medical center, and within thirty minutes drive of a state mental hospital. Easy access to preliminary psychiatric examination and proximity of state facilities undoubtedly influence the use of both.[7] A thorough evaluation of the operation of the

6. Conservatorship, used by California courts to channel persons into the mental health system, does not serve as an alternate channel of commitment in North Carolina. Incompetency proceedings, the North Carolina counterpart to California's conservatorship proceedings, have no effect on mental hospitalization, and vice versa (N.C.G.S. § 122-55). At no time in our study was the issue of incompetency raised in court. But, unlike California, had incompetency been found or had incompetency proceedings been initiated, the patient could not have been incarcerated in a mental hospital without a separate commitment procedure. Similarly, I did not observe the "bargaining" in chambers prior to the courtroom hearing that Warren (1977) found in California. Frequently, counsel talked with the hospital psychiatrist prior to the hearing, on the telephone or at the hospital, and negotiated release or a less restrictive alternative (see note 7 *infra*); but the judge was not a party to these negotiations.

7. For instance, only three petitions in our sample were emergencies, whereas in some rural mountain counties with few physicians, a large proportion of petitions are filed as emergencies. In those counties it is difficult to find local qualified physicians to examine the respondent, especially on weekends, so emergency procedures are followed. Respondents are taken directly to a state mental hospital even though they have not exhibited violent behavior which is statutorily required for bypassing this step.

new statute would have to include predominantly rural counties lacking medical centers and remote from state mental hospitals.

Our sample of persons whose commitment was sought differs slightly from the total population in North Carolina state mental hospitals, reflecting the difference between an urban, industrial county and a predominantly rural state (see Table 1). There are more males, more blacks, more single persons, and more urbanites in our sample. No education data are available, but other indicators reveal that our sample has the same low socioeconomic status as does the population in state mental hospitals. In our sample 77.2 percent are unemployed, 73.1 percent own no automobile or truck, and 84.8 percent own no real estate. Median monthly income is $100 for the 92 respondents whose records contain income information, and 45.7 percent of those had no income at all. Even if respondents without income are excluded, median monthly income only rises to $351.56. The 29 married respondents (out of 41 in our sample) for whom we know the spouse's income showed a median of $388 a month. These data should be viewed with caution since socioeconomic information is collected at the time of filing a petition for purposes of determining indigency, with the result that many respondents and petitioners are unwilling or unable to answer and the information they do provide may be distorted. Nonetheless, these data are consistent with courtroom observations of respondents' dress and speech: involuntary commitment is used primarily by the poor, the working poor, and the lower middle class. Seldom do middle class or upper class persons bring petitions against one of their own. Less than 10 percent of the sample had monthly incomes over $600 and only 2.3 percent had incomes over $1000 a month. Even when a

TABLE 1

COMPARISON OF ALL STATE MENTAL HOSPITAL ADMISSIONS[a] AND SAMPLED COUNTY INVOLUNTARY ADMISSIONS

	State	County
	%	%
Male	66.2	71.2
Black	25.5	43.2
Single	25.6	38.5
Urban	61.1	75.6
Did not complete high school	68.6	NA

a. State Mental Hospital Admission data courtesy of Statistics and Program Analysis Services, Division of Mental Health Services, North Carolina Department of Human Resources

middle class person enters the system, he frequently agrees to voluntary commitment or does not contest the involuntary commitment (3 of our 9 subjects with incomes over $600 did one or the other). As some middle class individuals stated through counsel, this avoids personal exposure in court hearings.

Petitions alleged that 55.5 percent of subjects were mentally ill, 39.1 percent were inebriate, and 5.5 percent had drug problems.[8] Petitions and physician records stated that 14.4 percent had been previously found dangerous to self or others, and 38.6 percent had been previously hospitalized and/or committed for mental illness or inebriety. But these figures on prior dangerousness and hospitalization do not necessarily represent historical truth. As brought out in court testimony, dangerousness was often exaggerated by a petitioner, and previous hospitalization was sometimes overlooked; however, the record of these conditions was important as a possible influence on diagnosis and recommendation. Indeed, we found that in the majority of cases psychiatrists assumed that behavior recited in the petition had actually occurred, even when the individual denied it and the court later found no evidence of it.

MEASUREMENT

The crucial question in the functioning of the court is whether judicial—rather than medical—decisions determine commitment. More specifically, the question is whether the court acts independently of psychiatric recommendation. Deference to psychiatric opinion was measured in four ways: (1) a court hearing lasting less than 5 minutes, (2) agreement between court decision and psychiatric recommendation 80 percent of the time or more, (3) commitment without a preponderance of the evidence supporting danger or imminence, and (4) failure of the judge to press witnesses for evidence of danger or imminence when counsel for the respondent did not bring out the lack of such evidence.

We shall focus on "danger" and "imminence" because: (1) the United States Supreme Court ruled that mentally ill persons cannot be involuntarily confined "if they are dangerous to no one and can live safely in freedom" (*O'Connor* v. *Donaldson,* 422 U.S.

8. Community officials were much less important in petitioning for commitment in our sample than in Warren's study. The majority of petitions were brought by close family members: 24.2 percent by spouses, 22.0 percent by parents, and 6.8 percent by children. Siblings accounted for 16.7 percent and "other relatives" for 6.1 percent. The remaining petitions were brought by physicians (11.4 percent), law enforcement officers (9.1 percent), neighbors or friends (3.0 percent), and social service workers (0.3 percent).

563, 575, 1975); (2) the statute requires a finding of clear, cogent, and convincing evidence of imminent danger (N.C.G.S. § 122-58.7); (3) questions of imminent danger are not as enshrouded in the cloak of medical expertise as are questions of mental illness and inebriety (in only three cases did judge or counsel question the presence of mental illness or inebriety); and (4) neither "dangerous" nor "imminent" is defined by statute, leaving great discretion to District Court judges.

For purposes of this paper, dangerous was defined as violent acts and threats of physical assaults to self or others, or to property (*Harvard Law Review,* 1974), and unintentional harm, such as wandering in front of traffic or inability to provide for basic needs. Imminent was defined, in the phrase of one of the judges in our sample, as a prediction that danger was likely to happen today, tomorrow, or within a week (Brooks, 1974) based on the occurrence of a dangerous act or threat on the day of petition or during the period of observation at the mental hospital. The standard of a mere preponderance of the evidence was chosen since it is a lower standard of proof than clear, cogent, and convincing evidence (McCormick, 1972). Because I determined whether the evidence showed imminent danger, it was appropriate that a lower standard of proof be used in order to mitigate the effects of my subjective appraisal of evidence.

The choice of benchmarks for the duration of the hearing and the frequency of agreement between doctor and judge was problematic. Previous studies have used no systematic cutoff points. Rather researchers have reported shock at the brevity of court hearings, which averaged less than five minutes, and at agreement between court decision and psychiatric recommendation, which often exceeded 50 percent. We, therefore, had to use our best judgment to establish rough indicators of deference to psychiatric opinion. The literature suggests that a hearing of at least five minutes and disagreement with psychiatric recommendation at least 20 percent of the time represent *minimum* standards of court independence of psychiatric opinion. We chose conservative estimates of deference to psychiatric opinion to avoid the fallacy of affirming the consequent. The fourth measure, failure of the judge to press witnesses for evidence of danger or imminence when counsel does not bring out the lack of such evidence, was viewed as an indicator that the court decided the case on the basis of psychiatric recommendation alone, since there is no lawyer to represent the petitioner or the state.

FINDINGS

When a psychiatrist[9] recommended release or a psychiatrist and an individual agreed to voluntary treatment, cause for commitment generally was seen to disappear and the case was dismissed. The dismissal was accomplished by a simple statement in court by the judge. At times, the judge would admonish an individual to be more careful or to seek help at a community mental health or alcoholic rehabilitation center. In only one case[10] where a psychiatrist recommended release did the court disagree. Since our concern focuses on prevention of unnecessary commitment, the brief duration of these cases where release was recommended shall not count as part of our measure of the independence of the judge.

In two (1.5 percent) of the 132 cases, the respondent ran away and in one case the respondent died before the hearing. Of those remaining, 59 (44.7 percent), were dismissed on a psychiatric recommendation of release or voluntary treatment[11] without a formal hearing—that is, without swearing of witnesses, presentation of evidence, or argument. For the 70 cases remaining (53.0 percent), court hearings averaged 18.5 minutes in length. The least time was

9. Psychiatrists make their recommendations through certified copies of standard forms containing basic demographic data, indications for mental illness or inebriety, and of imminent danger, diagnosis, recommendation, and a statement that the respondent "is (or is not) mentally ill or inebriate and imminently dangerous to himself or others." They are not required to attend the hearing (N.C.G.S. § 122-58.7 (e)); but the admissibility of the affidavit without further authentication cannot deny the respondent's right to cross-examination. If a psychiatrist were subpoenaed by the respondent and did not appear at the hearing, his affidavit could be challenged and rejected as hearsay evidence (*In re Benton,* 26 N.C. App. 294, 215 S.E. 2d 792 (1975)). In our sample, ten psychiatrists were subpoenaed but only two appeared in court. Sometimes their recommendation changed from commitment to release after receiving the subpoenas, or even after being threatened with a subpoena by counsel (personal conversation with five attorneys).
10. In that case commitment was ordered for an old man with organic brain syndrome whose extraordinary confusion and tendency to wander, fall and hurt himself required constant attention. The court could find no other place to keep him.
11. It might be argued that psychiatric recommendation of release or voluntary treatment in 44.7 percent of the cases contradicts the earlier assertion that psychiatrists tend to overpredict dangerousness. Such an argument ignores several important factors: (1) psychiatrists recommended commitment of over half the respondents; (2) counsel often negotiated with psychiatrists for release or some less restrictive alternative to commitment; (3) some attorneys "threatened" to subpoena psychiatrists to attend court hearings if they would not recommend release or a less restrictive alternative; (4) most respondents had been held in a treatment facility for 5 to 10 days before the hearing during which time acute episodes of dangerous behavior could have subsided spontaneously or with medication; and (5) 24.2 percent of all respondents were diagnosed as alcoholic, and 51.7 percent of these were recommended for release or other treatment. Since mental health professionals prefer not to work with alcoholics (Knox, 1973), it is not surprising to find psychiatrists getting rid of these patients by recommending release after the alcoholics had "dried out" during the observation and evaluation period.

devoted to those who waived their right to be present and did not contest the psychiatrist's recommendation—5.6 minutes. When the court ordered release or outpatient treatment, hearings averaged 22.3 minutes. When the court ordered involuntary commitment to a state mental hospital, hearings averaged 16.4 minutes. Measured by the criterion of the duration of the hearing, cases are being given adequate consideration, and there is little deference to psychiatric opinion.

In six of the 70 cases that were not dismissed, respondents waived their right to be present and did not contest the recommendation.[12] In 56 of the 64 cases argued in court, the psychiatrist recommended commitment. In 42 of these cases (75 percent), the judge agreed.[13] Agreement between psychiatrist and judge was less than our measure of deference; therefore, by this crude standard we again find little deference to psychiatric opinion. If agreement with psychiatric recommendation includes agreement with the recommendation to release, then deference increases slightly to 77.0 percent of all cases.

We hypothesized that the judge would most often agree with the psychiatric recommendation to commit when allegations of violence were substantiated in court. To test this hypothesis we divided danger into four categories of decreasing violence: (1) acts of violence: actual or attempted physical injury to oneself or another by beating, shooting, knifing, poisoning, etc.; (2) threats of violence: verbal warnings of future physical injury to oneself or

12. The respondents who waived their right to be present at the hearing were not different from the rest of the sample on any of our measures. Their demographic characteristics, alleged dangerous behaviors, and medical evaluations were varied. The only trait they shared in common was their sex. All were males.

13. It might be argued that agreement between psychiatric recommendation and court decision to commit reflected independent findings of mental illness or inebriety, and imminent danger to self or others, by psychiatrists and judges who just happended to agree. Undoubtedly, agreement between independent findings did occur in some cases; but, as discussed below, the court was *unable* to make an independent finding of imminent danger in many cases because neither judge nor counsel had adduced evidence indicating imminent danger. It might also be argued that agreement between psychiatric recommendation and court decision did not reflect deference to psychiatric opinion but rather a lack of alternative placement resources and the absence of family to take care of the respondent. The county studied was fortunate in having many alternative placement resources. Only the single individual mentioned above was committed because of a lack of alternatives. If a respondent was so disabled that his family had to care for him, then he would meet the one explicit criterion of imminent danger, inability to provide for basic needs. There were a few cases of elderly persons unable to provide for their basic needs whom the judge released to family members who wanted to take care of them, over a psychiatric recommendation of commitment. On the other hand, if the court were to follow a psychiatric recommendation to commit a respondent who was without family to care for him, but who was not found to be imminently dangerous, then, I would argue, the court was deferring to psychiatric opinion instead of making a legal decision. However, this type of deference was not observed in our study.

another, whether or not carried forward by some concrete act, such as buying a gun or poison; (3) unintentional harm: inadvertent action or inaction, such as wandering in front of traffic or not eating; and (4) no danger. We subdivided the danger in the first three categories into imminent and remote. A respondent was placed in the highest category that was substantiated in court by a preponderance of the evidence (see Table 2).[14]

TABLE 2

PROPORTIONS OF RESPONDENTS WHOM PSYCHIATRISTS RECOMMENDED FOR COMMITMENT AND WHOM JUDGES COMMITTED, BY EVIDENCE

Evidence	Total	Recommended for Commitment		Committed	
		N	%	*N*	%
Imminent danger of violent acts	10	10	100.0	10	100.0
Remote danger of violent acts	3	3	100.0	3	100.0
Imminent danger of violent threats	2	2	100.0	2	100.0
Remote danger of violent threats	11	9	81.8	7	63.6
Imminent danger of unintentional harm	5	3	60.0	4	80.0
Remote danger of unintentional harm	7	6	85.7	5	71.4
No danger	26	23	88.5	12	46.2
	64	56	87.5	43	67.3

The hypothesis was supported: agreement between court decision and psychiatric recommendation was greatest when evidence of violence was substantiated in court. As one moved from evidence of violent acts to no evidence of danger, agreement declined (Table 2). Although respondents differed as to whether they endangered themselves or others, this did not affect the decision of the court. Since the statute specifies that a person must be mentally ill or inebriate *and* imminently dangerous to self or others, all

14. It should be noted again that a standard of proof (preponderance of the evidence) lower than that required by statute (clear, cogent, and convincing) was used in determining danger and imminence in order to minimize bias on the part of the researcher. When there was doubt, the benefit was given to the judge. There were gross departures from evidentiary standards. In some cases there was no evidence of a respondent's behavior but only conclusory statements by witnesses and by psychiatrists (in affidavit). At other times, the behavior would not have been considered dangerous had it not been coupled with a psychiatric diagnosis of mental illness and a psychiatric recommendation to commit. For instance, one respondent was committed on the evidence that he had thrown one small rock five feet in the direction of relatives standing fifteen feet away, and another on the evidence that he had slept outside in a sleeping bag when it was 26°.

those in the remotely dangerous categories do not meet the legal criteria for commitment. This means that 27 respondents should not have been committed—42.2 percent of contested commitments or 20.5 percent of all cases. It is possible that some of those persons were imminently dangerous, but the preponderance of evidence presented in court did not support such a conclusion.

In 50.0 percent of observed cases, the judge questioned witnesses[15] about evidence of danger and imminence. In some of these as well as in others, counsel elicited evidence on those issues. But in 37.1 percent of the hearings neither judge nor counsel[16] raised the issues of danger or imminence. By this measure, too, the court exhibited deference to psychiatric opinion.

The significance of the failure of judge and counsel to elicit a preponderance of the evidence for imminent danger is that, in the absence of testimony, the court is unable to reach a decision independent of the psychiatrist's recommendation. In those situations, therefore, it was expected that there would be perfect agreement between judge and psychiatrist, and this agreement was found. Where either judge or counsel questioned the existence of imminent danger, we expected some, but not total, disagreement, since there is undoubtedly adequate evidence of imminent danger in many cases. And, indeed, agreement fell to 59.1 percent ($p < .01$). The most important indicator of deference, agreement with a psychiatric recommendation for commitment, fell from 100 percent to 56.8 percent ($p < .01$).

In those cases where the evidence of imminent danger was challenged or discussed by judge or counsel, commitment was significantly reduced, from 100 percent to 72.7 percent, even in cases where the researcher concluded that a preponderance of the evidence supported imminent danger. And in those cases where the researcher concluded that a preponderance of the evidence did *not* support imminent danger, commitment was reduced still further, from 100 percent to 30 percent. Were counsel and judge to exercise independent judgment in all cases—were they to press witnesses for evidence of imminent danger—it is likely that commitment would decline still further.

15. There were 1.70 witnesses per hearing on the average, ranging from none to seven. In just under two-thirds of the cases there were one or two witnesses; in ten, no witnesses were called to testify.
16. Although all respondents had counsel, not all attorneys chose to argue that their clients be released. Frequently, counsel deferred to psychiatric opinion or agreed with the psychiatric recommendation to commit, and did not attempt to demonstrate the absence of imminent danger. Only three respondents retained private counsel. Two of these attorneys strongly advocated the release of their clients, see note 2, *supra*. The other private attorney stated the willingness of his client not to contest the psychiatric recommendation to commit, and requested that no evidence be heard in court to prevent personal exposure.

A fifth, unexpected, measure of deference to psychiatric opinion developed during the course of observation: the judge's statement that he was ordering involuntary commitment following a psychiatric recommendation despite the lack of evidence of imminent danger. In one case, a lawyer effectively countered all the allegations in the petition, showing that the "withdrawn behavior" attributed to petitioner was listening to the World Series in his bedroom, that "not eating" was eating at his place of employment and at sandwich shops, that "inability to provide for basic needs" was contradicted by regular work, owning and maintaining his own house, and providing shelter for his brothers and sisters and their children (the petitioners), and that his "violence" was threatening to make these relatives move out of his house. At the conclusion of this hearing, the following dialogue ensued:

> JUDGE: I know we have no evidence of respondent's danger; but the psychiatrist says here [points to certified physician's report] that he [respondent] is schizophrenic and imminently dangerous.
>
> COUNSEL: How can he [the psychiatrist] say my client is dangerous? There is no evidence.
>
> JUDGE: They [psychiatrists] have ways of knowing—tests and tricks not known to us.

In 15.6 percent of the contested cases (29.0 percent of the contested cases where there was no independent inquiry into danger or imminence) the judge made such an explicit statement of blind deference to psychiatric opinion.

SUMMARY

New involuntary mental commitment laws were examined by studying court records and observing hearings in a representative state, North Carolina. Prior to the statutory reform, involuntary admission meant indefinite confinement in a mental hospital; court review could only be obtained by writ of habeas corpus. The new standards and procedures resulted in a substantial reduction in commitment: only 39.5 percent of respondents were committed involuntarily. Although these data are from one urban county with a major medical center, they are supported by findings from all four judicial districts in which North Carolina state mental hospitals are located. These judicial districts committed less than half of all respondents against whom involuntary proceedings had been brought (Hiday, 1976).

Psychiatric recommendations against commitment, sometimes at the urging of counsel or under threat of subpoena, account for 49.3 percent of respondents released. Judges generally felt that such a recommendation eliminated any cause for commitment, and consequently dismissed the case. However, judges did not show the same deference to psychiatric opinion that has been described in studies of commitment practices in other states prior

to recent statutory reforms. Two measures indicated the court's independence of psychiatric opinion: the duration of hearings was longer than our benchmark of five minutes, averaging 18.5 minutes; and court agreement with psychiatric recommendation of commitment was slightly less than our benchmark of 80 percent, reaching only 75.0 percent in contested cases. However, two measures indicated some deference to psychiatric opinion: 20.5 percent of all respondents were committed without a showing, by a preponderance of the evidence, that there was imminent danger due to mental illness or inebriety; and in 37.1 percent of contested cases neither judge nor counsel pressed for evidence of imminent danger. In these latter cases the court ordered commitment every time a psychiatrist recommended it; but where either judge or counsel inquired about imminent danger 43.2 percent of those for when psychiatrists recommended commitment were released.

Although fewer individuals are being involuntarily committed to mental hospitals and although court officials are not deferring to psychiatric opinion in the great majority of contested cases, we still find numerous instances of deference and commitment where a preponderance of evidence does not support imminent danger to self or others. Informal conversations with judges and attorneys suggest that they defer to psychiatric opinion because they feel they lack the requisite expertise and want to obtain help for those in need. Mr. Justice Brandeis warned about such thinking:

> Experience should teach us to be most on our guard to protect liberty when the Government's purposes are beneficent. Men born to freedom are naturally alert to repel invasion of their liberty by evil-minded rulers. The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding. [*Olmstead* v. *U.S.*, 277 U.S. 438, 479 (1928)]

Civil commitment contains inherent tensions between a benevolent ideal of treatment for the mentally ill and the harsh reality that we do so by incarcerating many against their will. This unresolved tension is manifest in our data, which show the court acting both paternalistically in following psychiatric opinion without adequate review and also "judiciously" in refusing to commit in the absence of clear, cogent, and convincing evidence of imminent danger.

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